

# American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

February 18, 2011

Statement of  
**Robert Zarr, MD, MPH, FAAP**

On behalf of the  
**American Academy of Pediatrics**

Before the  
**Department of Health and Human Services Negotiated Rulemaking  
Committee on Designation of Medically Underserved Populations and  
Health Professional Shortage Areas**

Good afternoon. Thank you to the Committee for this opportunity to comment on the designation of medically underserved populations and health professional shortage areas. My name is Robert Zarr, MD, MPH, FAAP, and I am proud to represent the American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the optimal physical, mental, and social health and well-being of all infants, children, adolescents, and young adults. I welcome the opportunity to expand upon the Academy's written comments presented to you last month.

I am a pediatrician at Unity Health Care, Inc in Washington, DC, where I care for low-income and immigrant populations. I hold adjunct professorships at Children's National Medical Center, George Washington University, and Georgetown University. I also currently serve as President of the DC Chapter of the American Academy of Pediatrics.

AAP maintains that the health care needs of infants, children, adolescents, and young adults will be significantly affected by the decisions reached by this Committee. Therefore, as the Committee works to develop recommendations AAP wanted to take this opportunity to reiterate our key concerns and highlight ways the unique health needs of children can be appropriately addressed.

First, children should be considered a special population because they are more than just little adults. Children have unique health needs and disabilities that need to be taken into account when defining what constitutes a special population. As we are all well-aware, an increasing proportion of children suffer from chronic illnesses that require additional health care and management to ensure they live a long, healthy life. Further, the issues created by distance and other realities in rural areas have a unique impact on access to care for children, because the shortages of both primary care pediatricians and pediatric subspecialists in these communities are much more impactful. More than half of children living in less populous areas have no access to pediatricians in their primary care service area, while more than one-sixth of children lack access to either a pediatrician or family physician in their primary care service area. Therefore, geographic barriers disproportionately impact children, and their unique needs must be represented as a special population.

Additionally, children who are from racial/ethnic minorities, living in poverty, uninsured, or living in families whose primary language spoken at home is not English should also be considered special population groups.

A second important consideration is the indicators used in determining health status. Infant mortality rate alone does not adequately address the special health care needs and

access of the pediatric population. Other key measures might include preterm births, low birth weight, immunization rates, as well as childhood mortality and the number of children who have special health care needs. Additional measures that merit consideration include: insurance status (eligibility/enrollment/medical home), births to teens, race/ethnicity, out of home placement, obesity/overweight, asthma, intentional and unintentional injuries, poverty, education status, and other risk behaviors such as tobacco, alcohol, or drug use.

Third, the measures used to quantify provider availability and utilization of health services need to accurately represent the pediatric population. For instance, availability of pediatricians/child population should be a specific measure rather than primary care provider/total population since internists do not provide pediatric care and the number of family physicians who provide care for a pediatric population continues to decrease. When defining provider availability, measures of distance to care and wait time for appointments should be considered for inclusion. In pediatrics, the best measures of utilization would be health supervision visits in accordance with those recommended in the current version of the AAP *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, as well as prenatal visits. Finally, the definition of full-time equivalent (FTE) should be measured by hours of clinical patient care.

Lastly, some areas of the country may have adequate access to health care for adults but not children. For example, in a particular area, the percent of those with access to care through Medicare may be different from those with access through Medicaid, as many practices limit the number of Medicaid patients they treat due to low Medicaid payments and administrative difficulties. Therefore, maintaining a singular measure for both adults and children may inappropriately distort results. It would be helpful to measure child and adult population access to care separately.

The proper definition of each of the above mentioned areas of medically underserved populations and health professional shortage areas impacts the health of many children, and thus, we appreciate greatly your consideration of our comments.

The AAP stands ready to assist the Committee in any capacity so as to insure that a pediatric perspective, information, and/or data is available to assist you in your deliberations.

Thank you again for this opportunity. The AAP looks forward to future collaborations.